STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155631	A. BUILDING 00 B. WING	09/29/2011

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WHITE RIVER LODGE LTD	3710 KENNY SIMPSON LN BEDFORD, IN47421

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F0000	This visit was for recertification and state licensure survey. This visit included the investigation of Complaint IN00096151. Complaint IN00096151-Substantiated, no deficiencies related to allegation cited. Survey date: September 26, 27, 28 and 29, 2011 Facility number: 001153 Provider number: 155631 AIM number: 200155900 Survey team: Marla Potts, RN, TC Melinda Lewis, RN Sharon Whiteman, RN (September 26, 27, and 28, 2011) Census bed type: SNF/NF: 51 Residential: 9 Total: 60 Census payor type: Medicare: 3 Medicaid: 43 Other: 14 Total: 60 Sample: 15	F0000	Preparation and execution of the plan of correction for the survey does not constitute admission of agreement by this provider of teh truth of the facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and executed solely because it is required by the Federal and State law. This provider maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of its residents; nor are they of such character as to limit the provider's capacity to render adequate resident care. This plan of correction serves as the facility's written credible allegation that it will be in substantial compliance on or before October 29, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Supplemental Sample: 1 Residential Sample: 7 These deficiencies also reflects state findings cited in accordance with 410 IAC 16.2. Quality review completed 10/3/11 Cathy Emswiller RN			

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F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on record review and interview the facility failed to ensure staff reported an allegation of physical abuse timely to the health facility administrator for 1 of 1 residents with abuse allegations	F0225	The facility does ensure that staff reports allgations of abuse to the facility administration timely. Facility policy includes notification of administration which is and has been posted at the nurses station	10/21/2011

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	reviewed,in the supplemental sample of 1. Resident 15. Findings include: During interview with the Health Facility Administrator[HFA] on 9/27/11 at 11:00 A.M. she indicated the only abuse investigation conducted happened in May and was not reported to the state agency as it was determined two CNA's had a personal dispute rather than actual abuse having occurred. The HFA provided the investigation at that same time. The investigation included written statements signed by the ADON[Assistant Director of Nursing] as follows: "5/23/11 at 1:10 p.m. [CNA #1 name] made comment while getting pay check Asked to clarify and indicated she reported concern Thursday 5/19/11 [name of RN 1] about co worker [name of CNA #2] Reported demonstrated touching shoulder and little shove and hand over mouth. Questioned her why not report? Adamant 'I told RN #1' Counseled on need to report to administration if concern issue not addressed. Took CNA to HFA to have relay information." "5/23/11 RN #1 phoned in at 1:45 P.M. CNA #1 had phoned[honed him and		and in the charting areas. The nurse that failed to report the allegation in a timely manner was counseled on May 25, 2011 and reinstructed on proper reporting requirements based on facility policy. In addition, he was instructed to present training to the 2 aides involved to assure that they were aware of proper identification and reporting. This was reviewed by the survey team during survey. The facility has re-inserviced all staff on abuse and administrative notification as follows:8/23/11 All licensed nurses on notification of administrator policy and reasons for notification;9/28/11 All staff resident safety and abuse;10/7/11 Mandatory all staff abuse reporting, what constitutes abuse and investigative protocol and notification requirements.Facility administrative personnel reviews all nursing documentation and 24 hour reports on a regular basis on regular scheduled work days. This allows staff to note if there are issues documented that may need additional investigation. Facility does provide, at the time of general orientation, a synopsis of abuse prevention and review of facility policy. A criminal background check is conducted at the time of hire. Facility also encourages residents and families to report any concerns to facility staff. Administrator does attend monthly resident council	

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	reported she spoke with me when in facility. RN #1 states 'totally forgot' CNA #1 had indicated in passing CNA #2 had put hand on face and pushed resident but did not express 'abuse' Just in comment about 'can't work with CNA #2 anymore.' RN #1 didn't 'feel physically harmed resident' Reports he did not assess patient at time but did see her during med pass-nothing significant noted. RN #1 reports CNA #1 followed the chain of command." "5/23/11 spoke with night nurses, LPN #1, #2 and RN #2 all indicate no concerns with CNA #2 abusive to residents. Do acknowledge gets job done, bedside manner lacking at times but cares for residents...CNA #2 encourages peers to do their jobs. All 3 nurses indicate issue between employee CNA 1 and CNA 2. All advised to be observant to avoid accusation/allegations against each other, will try to avoid scheduling together when can." "5/23/11 CNA#2 here at facility at 3:30 p.m. questioned regarding shift 5/19/11 early am nothing significant recalled..recalled resident #15 awake loud 'like usual' She indicates soothing resident 'patted shoulder' she thinks but not sure when giving last bed check care (this resident care planned to touch at times		meetings at the request of the council membership. There have been no reports of allegations of abuse from residents. This was re-addressed with the council on 10/11/11 at their monthly meeting. Residents denied any issues and indicated understanding of how to report concerns. The facility will continue with policies currently in place and assure that staff reports concerns timely and appropriately. This will be assured through routine walking rounds in the facility by administrative staff as well as routine record reviews. The facility will continue to have at least annual training for all staff on abuse prevention and reporting. Administrator will report negative findings monthly to facility QA committee.	

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	loud to calm down). A typed statement indicated"5/24/11 discussion with RN #1 to clarify 5/23/11 information. RN #1 on speaker phone with ADON and DON [Director of Nursing] Indicated in am of 5/19/11- CNA #1 commented to him 'can't stand to work with CNA #2 anymore, put hand on Resident #15 face and pushed. Resident #15 yelling guesses why CNA #2 did it.' When RN #1 questioned what did at that point indicated he planned to speak with ADON name later but 'forgot'. Indicated 'didn't feel or take it as physical harm and needed to go check Resident #15. Do not feel CNA #2 would do that'...asked to describe CNA #2 demeanor...indicated 'grippe' 'blunt with coworkers' 'straight up front' 'She wants to get work done and personality is that way, gets it done. Doesn't take extra time to build repor (sic) and sometimes may come across crude.' RN #1 reiterated awareness of dropping ball and that 'didn't feel harm or abuse occurred.' RN to be written up, he has been given education and able to verbalize understating concerning abuse, immediate intervention of any allegation and protecting residents..." "5/25/11 CNA#1 in facility and interviewed CNA #1 demonstrated on DON what she saw coworker CNA 2 do			

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	in am of 5/19/11 at last bed check. put 4 fingers to side of DON's mouth and cheek region and gave shove. CNA 1 denied reporting shove to shoulder as reported to this nurse and HFA on 5/23/11...reports residents kept hollering like she does...RN will address untimely/inappropriate reporting of concern via write up." "5/25/11 Discussion with CNA #2 regarding 5/19/11 morning allegation via phone conversation, CNA #2 denies doing anything to harm Resident. Indicates she has in past on approximately 2 occasions placed fingertips on lips and patted like the Indian game to try and distract patient. CNA reports did little to help but didn't cause her distress either. indicates no recall of doing this am of 5/19/11...RN will review resident rights/dignity and inappropriate interventions redirection via write up. " During interview with the ADON on 9/27/11 at 1:00 P.M., she indicated that during the reenactment by CNA #1 of what she had observed CNA #2 do, it became aware that with one CNA on each side of the bed, CNA #1 could not have observed everything CNA #2 was doing. 3.1-38(b)(1)			

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F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to ensure CNA #1 and RN #1 followed policies and procedure for immediately reporting allegation of abuse to the facility administrator, and the facility failed to report an allegation of abuse to the state agency, for 1 of 1 abuse investigations reviewed, which affected 1 of 1 supplemental resident in the supplemental sample of 1. Resident #15 Findings include: During interview with the Health Facility Administrator[HFA] on 9/27/11 at 11:00 A.M. she indicated the only abuse investigation conducted happened in May and was not reported to the state agency as it was determined two CNA's had a personal dispute rather than actual abuse having occurred. The HFA provided the investigation at that same time. The investigation included written statements signed by the ADON[Assistant Director of Nursing] as follows:	F0226	The facility does thoroughly invstigate all unusual occurrences and allegations of abuse and or neglect. All are reported to State agencencies as required by law.Facility policy on immediate administrator notification of any misconduct allegation is posted and has been reviewed with all staff on 10/7/11. Facility administrator makes regular walks through the facility and observes staff and resident interactions during the course of the facility day. Administrator attends monthly resident council meetings at request of residents and has received no vocalized concerns regarding staff treatment of residents. Facility administrator does review any resident concerns and responds to the resident, family and /or the resident council. Facility administrator will report monthly in QA any investigations completed and results of any calls to the State agency.	10/10/2011

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	"5/23/11 at 1:10 p.m. [CNA #1 name] made comment while getting pay check Asked to clarify and indicated she reported concern Thursday 5/19/11 [name of RN 1] about co worker [name of CNA #2] Reported demonstrated touching shoulder and little shove and hand over mouth. Questioned her why not report? Adamant 'I told RN #1' Counseled on need to report to administration if concern issue not addressed. Took CNA to HFA to have relay information." "5/23/11 RN #1 phoned in at 1:45 P.M. CNA #1 had phoned[honed him and reported she spoke with me when in facility. RN #1 states 'totally forgot' CNA #1 had indicated in passing CNA #2 had put hand on face and pushed resident but did not express 'abuse' Just in comment about 'can't work with CNA #2 anymore.' RN #1 didn't 'feel physically harmed resident' Reports he did not assess patient at time but did see her during med pass-nothing significant noted. RN #1 reports CNA #1 followed the chain of command." "5/23/11 spoke with night nurses, LPN #1, #2 and RN #2 all indicate no concerns with CNA #2 abusive to residents. Do acknowledge gets job done, bedside manner lacking at times but cares for residents...CNA #2 encourages peers to do			

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	their jobs. All 3 nurses indicate issue between employee CNA 1 and CNA 2. All advised to be observant to avoid accusation/allegations against each other, will try to avoid scheduling together when can." "5/23/11 CNA#2 here at facility at 3:30 p.m. questioned regarding shift 5/19/11 early am nothing significant recalled..recalled resident #15 awake loud 'like usual' She indicates soothing resident 'patted shoulder' she thinks but not sure when giving last bed check care (this resident care planned to touch at times loud to calm down). A typed statement indicated"5/24/11 discussion with RN #1 to clarify 5/23/11 information. RN #1 on speaker phone with ADON and DON [Director of Nursing] Indicated in am of 5/19/11- CNA #1 commented to him 'can't stand to work with CNA #2 anymore, put hand on Resident #15 face and pushed. Resident #15 yelling guesses why CNA #2 did it.' When RN #1 questioned what did at that point indicated he planned to speak with ADON name later but 'forgot'. Indicated 'didn't feel or take it as physical harm and needed to go check Resident #15. Do not feel CNA #2 would do that'...asked to describe CNA #2 demeanor...indicated 'grippe' 'blunt with coworkers' 'straight up			

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	front' 'She wants to get work done and personality is that way, gets it done. Doesn't take extra time to build repor (sic) and sometimes may come across crude.' RN #1 reiterated awareness of dropping ball and that 'didn't feel harm or abuse occurred.' RN to be written up, he has been given education and able to verbalize understating concerning abuse, immediate intervention of any allegation and protecting residents..." "5/25/11 CNA#1 in facility and interviewed CNA #1 demonstrated on DON what she saw coworker CNA 2 do in am of 5/19/11 at last bed check. put 4 fingers to side of DON's mouth and cheek region and gave shove. CNA 1 denied reporting shove to shoulder as reported to this nurse and HFA on 5/23/11...reports residents kept hollering like she does...RN will address untimely/inappropriate reporting of concern via write up." "5/25/11 Discussion with CNA #2 regarding 5/19/11 morning allegation via phone conversation, CNA #2 denies doing anything to harm Resident. Indicates she has in past on approximately 2 occasions placed fingertips on lips and patted like the Indian game to try and distract patient. CNA reports did little to help but didn't cause her distress either. indicates no recall of doing this am of 5/19/11...RN			

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	will review resident rights/dignity and inappropriate interventions redirection via write up. " During interview with the ADON on 9/27/11 at 1:00 P.M., she indicated that during the reenactment by CNA #1 of what she had observed CNA #2 do, it became aware that with one CNA on each side of the bed, CNA #1 could not have observed everything CNA #2 was doing. The policy and procedure for "Resident Safety Abuse Statement," dated 11/08 and updated 1/11, provided on 9/28/11 at 1:00 P.M. by the HFA, included: "Abuse is the willful infliction of injury...intimidation ...with resulting physical harm, pain or mental anguish....any suspected, observed or reported violation of this resident safety policy or any observed unexplained injuries to a resident will be reported to the supervisor and the DON and/or Health Facility Administrator per facility policy immediately...The DON or the designee will notify the Administrator if they are the first contact...The administrator of designee will determine if notification should be made to the appropriate state agencies..." The HFA provided the policy and procedure for "Reportable unusual			

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	Occurrences", dated 3/3/06, on 9/28/11 at 1:00 P.M. The policy included: Facilities are required by law to report unusual occurrences within 24 hours of occurrence to the long Term Care Division...the facility must ensure that all alleged violations involving mistreatment, neglect, abuse... are reported immediately to the administrator and to other officials...including to the state agency and certification agency. 3.1-38(b)(1)			
F0368 SS=E	Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. Based on interview, the facility failed to offer all residents of the facility a bedtime snack, for 10 of 10 residents interviewed	F0368	The facility does supply bedtime snacks for all residents. The survey team noted 10 residents	10/28/2011

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	during the group meeting. Resident # 2, 18, 25, 28, 7, 10, 20, 27, 6, 36. Findings include During the group meeting, on 9/27/11 at 10:00 A.M., 10 residents identified by the facility activity director to be alert and oriented indicated the facility did not offer bedtime snacks to each resident. They stated the diabetics all got a nightly snack, and you could get one if you went to the nurses station and requested one. They indicated they would enjoy a bedtime snack. In an interview with Dietary Aide # 1, on 9/27/11 at 2:30 P.M., she indicated she only sent out snacks to the residents on the list. She then provided a list of 22 residents which was sent a bedtime snack. In an interview with the Assistant Director of Nursing, on 9/27/11 at 3:15 P.M., she indicated the snacks are not documented because all the residents are on a level diet. In an interview with CNA # 3, on 9/27/11 at 3:30 P.M., she indicated if the resident's wanted a snack at bedtime all they had to do was ask.		who indicated that they were not offered a a bedtime snack. Of the 10 identified on the survey, 3 are diabetics and are sent routine bedtime snacks. The residents acknowledged to the survey team that diabetics did routinely receive bedtme snacks and others were given them if they asked. The facility does assure that all residents have the option of having a snack at their discretion as we follow a LIBERAL diet plan for our residents.The facility will have evening shift staff note on the C.N.A. assignment sheets each evening if the resident took or refused the HS snack. The aide assignment sheets are turned into the charge nurse at the end of each shift. The charge nurse will monitor assignment sheets and through observation of resident care for compliance with snack offerings.Residents will be polled monthly at resident council meetings for 3 months regarding snack offerings. Negative findings will be reported to facility QA committee.DON will monitor through review of assignment sheets weekly and report findings to QA committee monthly for 90 days, then negative findings quarterly for 6 months.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-21(e)			
F0463 SS=F	The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.			

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	155631	A. BUILDING 00 B. WING	09/29/2011

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	Based on observation and interview, the facility failed to ensure call lights were audible in the rooms where nurses and CNA's charted, in that call lights could only be heard at the old nursing station, no longer utilized by facility staff as a working nurses station, for 14 of 15 sampled residents. This had the potential to affect all 52 residents who reside in the facility. Findings include On 9/27/11 at 3:50 P.M., RN # 3 was observed to be passing pills on the 200 hall. RN # 3 was observed to be standing in a doorway preparing medications as the call light above her was on. On 9/27/11 at 4:00 P.M., in an interview with RN # 3 she indicated when on the hall the call lights were only visible and did not sound. She stated she did not know the call light was on. RN # 3 further indicated she thought the bathroom emergency call lights did notify staff both visually and audibly. RN # 3 then turned on a bathroom call light but the call light was only visual. The call light system did sound at the former nurses station and in the dining room. The current charting room where the resident records are maintained and	F0463	The facility nurses station does have a call light system that is equipped to receive resident calls. This does include lighted lights over each resident room and audible beeping in the nurses station area and halls. The facility contends that the existing system is audible and can be heard by staff. In good faith, the facility has added speakers in each hallway and the charting areas to enhance the audible signal.The facility Maintenance Director will do daily checks on the nurse call system for 30 days and then monthly for 90 days and report negative findings to facility QA committee. The facility administrator or designee will interview at least one resident each week per hall for 6 weeks regarding staff response to call lights and report negative findings to facility QA committee. Call light response will also be addressed in resident council meetings for resident feedback.	10/12/2011

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	where the nurses work did not have a call panel to enable them to visualize or hear the call system. In an interview with the Administrator, on 9/27/11 at 4:30 P.M., she indicated she was not aware the call system could not be heard in the current charting room. 3.1-19(u)(1) 3.1-19(u)(2)			

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F0505 SS=D	The facility must promptly notify the attending physician of the findings. Based on record review, the facility failed to notify the physician of an abnormal lab results for a resident receiving Coumadin (blood thinner) for 8 days after the facility received the results for 1 of 13 residents reviewed for lab work in a sample of 13. Resident # 25 Findings include: The clinical record for Resident # 25 was reviewed on 9/28/11 at 10:00 A.M. The record indicated Resident # 25 had diagnoses that included but were not limited to CVA [cerebrovascular accident] (stroke). The Treatment Administration Record (TAR) for 8/2011 indicated Resident # 25 had a PT, INR [protime, International Normalization Ratio] due every 2 weeks for coumadin therapy. The TAR indicated the lab work was drawn on 8/31/11.	F0505	The facility does notify the physician promptly of lab results. The PT/INR results had been faxed on 8/31/11 to the physician's office. In addition, the results were sent with the resident on 9/6/11 when the resident was seen by the physician at his office. The physcian made no reswponse until 9/7/11.The facility has reviewed response times with facility Medical Director. Should the Primary Care Physician fail to respond to abnormal lab but NON CRITICAL values within 24 hours, then the charge nurse will contact the Medical Director for guidance and possible order changes. Nursing staff was re-instructed regarding physician notification with completion by 10/19/11.In addition, the facility has contacted the contracted lab for follow up with lab reports. All lab reports are either faxed or sent hard copy to the attending physician based on that physician's preference by the lab personnel. This is in addition to the copies faxed to the	10/19/2011

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	The lab results indicated it was faxed on 8/31/11 at 9:04 A.M. with the results of PT 38.7 (normal range 9.0-11.0) INR 3.65 (normal range 0.88-1.12). The clinical record lacked any documentation of the facility attempts to notify the physician of the results until receiving a physician order on 9/7/11. A Physician order, dated 9/7/11, indicated "1. Discontinue previous Coumadin orders. 2. Coumadin 5 mg T, TH, SA, Sunday [Tuesday, Thursday, Saturday, Sunday]. Coumadin 7.5 mg 3 x wk M-W-F [3 times a week Monday, Wednesday, Friday]." On 9/29/11 at 9:00 A.M., the Director of Nursing provided the facility policy and procedure for Change in Resident's Condition/Status: Resident, Physician and Family/Legal Representative Notification/Consultation, dated 1/11. The policy indicated "...The attending physician should be informed of the event during normal office hours, and generally no later than the next regular office day..." 3.1-49(f)(2)		facility by the lab. The clinical record will reflect communication with either primary care physician and or Medical Director and results of that contact. The DON will review 24 hour report sheets, nurses notes and lab results daily to ensure compliance. The DON will report negative findings to facility QA committee monthly for 90 days.	

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